## CITY OF WEST LAFAYETTE FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM FORM

| P                                   | lease Read   | d These Instruc          | tions E                          | Before   | Completi   | ng the F                                      | SA With                                    | drawal Request   |   |  |
|-------------------------------------|--|--------------------------|----------------------------------|--|--|---|--|--|---|--|
| Employee must con<br>Expenses.)     | nplete <b>Part</b>   | 1. (If applicable        | e, comp                          | lete Pa  | rt 2 Healt   | h Care E                                      | kpenses                                    | and/or Part 3 Depe   | ndent Care  |  |
|                                     |  |                          |                                  |  |  |   |  |  |   |  |
| 2. Instructions for Part            | t 2:   |                          |                                  |  | a.£ 4b.a.  | Customati                                     | an of D                                    | nofita (EOP) alana   | with your ESA                                       |  |
| A. If expenses were                 | A. If expenses were covered by any benefit plan, attach a <b>copy</b> of the Explanation of Benefits (EOB) along with your FSA withdrawal form. Your insurance carrier (or spouse's carrier or any individual plan) should pay before you request an FSA |                          |                                  |  |  |   |  |  |   |  |
|                                     | insurance  | carrier (or spou         | se's cari                        | rier or a  | any individ  | iuai pian)                                    | snoula                                     | pay before you requ  | lest an FSA   |  |
| reimbursement.                      |  |                          |                                  |  |  |   |  |  |   |  |
| B. If expenses are r                |  |                          | plan, att                        | ach a  | copy of a  | n itemize                                     | d receipt                                  | that includes the da   | ates of service,                                    |  |
| service rendered, and               | total charge   | 9.                       |                                  |  |  |   |  |  |   |  |
| 3. Instructions for Part            | t 3: Attach  | a copy of a rec          | eipt that                        | includ   | es the dat   | es of ser                                     | vice, day                                  | y care provider's nai  | me, and amount                                      |  |
| paid to day care provid             | ler or attacl  | n a <b>copy</b> of a ca  | ncelled                          | check  | from the o   | day care i                                    | orovider                                   | •  |   |  |
| 4. Read the Certification           | on For Rein  | mbursement, sic          | n and                            | date th  | e form.  | Make a c                                      | opy for                                    | your records.  |   |  |
| 5. Mail the form to the             | address or   | rovided on this f        | orm. Al                          | reimb  | ursement   | requests                                      | for a pla                                  | an vear made during  | the following                                       |  |
| year must be postmark               | ed prior to  | the filing deadli        | ne whic                          | h is sn  | ecified in   | vour plan                                     | docume                                     | ents   |   |  |
| year must be postmark               | tea prior to   | the ming deadin          | ic, wille                        | #1 13 3p   | comea iii  | your plan                                     | aooann                                     | J. 1   |   |  |
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|                                     |  | FORMATION                |                                  | e Prin   |  |   |  |  |   |  |
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| First                               |  |                          |                                  |  |  |   |  |  |   |  |
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|                                     |  |                          |                                  |  |  |   |  |  |   |  |
| EMPLOYEE ADDRES                     | S  |                          |                                  | CITY   |  |   | Y, STATE, ZIP                              |  |   |  |
|                                     | •  |                          |                                  |  |  | ,   | ,  |  |   |  |
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|                                     |  |                          | /DL                              |  | 51   |   |  |  | navata lina   |  |
| PART 2 HEAL                         | THCAR  |                          |                                  |  |  |   |  |  |   |  |
|                                     |  | E EXPENSES               |                                  | ase Pr   |  | ease pla                                      | ce eacr                                    | n expense on a se  |   |  |
| PATIENT'S NAME                      | DATE(S)  | OF SERVICE               | TYPE                             | OF SE  | ERVICES  |   |  |  | REQUEST   |  |
|                                     |  | OF SERVICE               | TYPE                             | OF SE  | RVICES   | priate bo                                     | k below 1                                  | for each expense(s)  |   |  |
|                                     | DATE(S)<br>MM/DD/Y   | OF SERVICE<br>YYY        | TYPE                             | OF SE  | RVICES   | priate bo                                     | k below 1                                  |  | REQUEST   |  |
|                                     | DATE(S)  | OF SERVICE               | TYPE<br>Please<br>MD=m           | OF SE<br>e check<br>nedical                            | RVICES<br>the appro  | priate bo<br>iption VS=                       | <b>k below f</b><br>vision DI              | for each expense(s)<br>N=dental HR=hearing   | REQUEST   |  |
|                                     | DATE(S)<br>MM/DD/Y   | OF SERVICE<br>YYY<br>TO: | TYPE                             | OF SE  | RVICES   | priate bo                                     | k below 1                                  | for each expense(s)  | REQUEST   |  |
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|                                     | DATE(S)<br>MM/DD/Y<br>FROM:<br>FROM:   | OF SERVICE YYY TO: TO:   | TYPE<br>Please<br>MD=m           | OF SE<br>e check<br>nedical                            | RVICES<br>the appro  | priate bo<br>iption VS=                       | <b>k below f</b><br>vision DI              | for each expense(s)<br>N=dental HR=hearing   | REQUEST   |  |
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I certify that the expenses for reimbursement requested from my FSA were incurred by me (and/or my spouse and/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my FSA. I (or/we) will not use the expenses reimbursed through the FSA program as deductions or credits when filing my (our) income tax return.

## **EMPLOYEE SIGNATURE:**

DATE:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

## CITY OF WEST LAFAYETTE FLEXIBLE SPENDING ACCOUNT (FSA) CLAIM FORM

Please complete the information on the other side of this page and review the following reminders to ensure accurate and timely processing of your request:

- Is your participant ID number included on the form?
- Is your total requested amount included on the form?
- Did you attach copies of your itemized documentation with your request?
- ♦ Did you sign and date the bottom of this form?
- Have you made copies of your request for your own personal records?

The following examples are eligible for reimbursement through the Health Care Spending Account:

- ✓ Acupuncture
- ✓ Chiropractic services
- ✓ Coinsurance/Copays
- ✓ Contact lenses and solutions
- ✓ Deductibles
- ✓ Dental Expenses
- ✓ Dentures
- ✓ Diabetic supplies

- ✓ Guide dogs
- ✓ Hearing aids/batteries
- ✓ Laboratory Fees
- ✓ Laser eye surgery
- ✓ Childbirth expenses
- ✓ Orthodontia
- ✓ Pediatric services
- ✓ Prescription drugs
- ✓ Psychological treatment
- ✓ Speech therapy
- ✓ Surgical fees
- ✓ Transportation fees necessary for medical treatment
- ✓ Vaccinations
- ✓ Vision expenses

The following examples are ineligible for reimbursement through the Health Care Spending Account:

✓ Cosmetic procedures and supplies

✓ Amount reimbursable through another benefits plan

✓ Marriage/family counseling

- ✓ Weight reduction programs for general health
- ✓ Premium payments for health, dental, or vision care coverage

The following examples are eligible for reimbursement through the Dependent Care Spending Account:

- ✓ Care for a dependent under the age of thirteen or a qualified individual incapable of self-care
- ✓ Qualified child care centers✓ After school programs

- ✓ Licensed nursery school
- ✓ Adult day care facilities

The following examples are ineligible for reimbursement through the Dependent Care Spending Account:

- ✓ Sleep away overnight camps
- ✓ Tuition fees for private or boarding homes
- √ 24-hour nursing home care
- ✓ Weekend or evening baby-sitting that is not necessary for you (and your spouse) to work
- ✓ Care provided for your child by a sibling under the age of 19 or someone you claim as a dependent on your income tax return
- ✓ Expenses for which you claim a tax credit on your federal tax income return

The above are some examples for eligible/ineligible expenses that can currently be reimbursed through Flexible Spending Account. If you have any expense that is in question, please feel free to contact the Administrator's Office at 800-552-6550.

Claims are to be filed to the following address:

City of West Lafayette Flexible Spending Account
Claims Administrator
P.O. Box 5769
Lafayette, IN 47903-5769